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ABSTRACT

Using an evaluation of a hospital-based hospice as a case study, this paper analyzes problematic issues surrounding health care teams (HCTs) in light of findings revealed in the literature concerning HCT structures and processes. The factors of coordination and role definitions in HCTs and their manifestations in a particular hospice HCT in terms of both interpersonal dynamics and structural constraints are discussed. This is followed by a review of external and internal efforts that were undertaken to improve the hospice's HCT, including the creation of a three-stage intervention program recommended by the program evaluators. (Author/FL)

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Problems Associated with Coordination and Role Definitions in Health Care Teams: A Hospice Program Evaluation and Intervention Case Study

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Running Head: COORDINATION AND ROLES IN HCTs

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Abstract

Using an evaluation of a hospital-based hospice as a case study, this paper analyzes problematic issues surrounding health care teams (HCTs) in light of findings revealed in the literature concerning HCT structures and processes. Specifically, we discuss the factors of coordination and role definitions in HCTs, their manifestations in a particular hospice HCT in terms of both interpersonal dynamics and structural constraints, and follow this with a review of external and internal efforts that were undertaken to improve the hospice's HCT.

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Problems Associated with Coordination and Role Definitions in Health Care Teams: A Hospice Program Evaluation and Intervention Case Study

Health care teams (HCTs) have become a popular alternative to conventional health care (Royer, 1976; Thornton, 1977; Wise, 1974). Composed of physicians, nurses, social workers, psychologists, and other health care providers, these teams are used in neighborhood and community clinics and hospitals, teaching hospitals, and university associated hospitals. Generally speaking, an HCT is an interdisciplinary group of caregivers who coordinate their efforts in order to provide a designated type of health or patient care. One of the oldest types of HCT is the surgery team, in which members of different disciplines work together to perform the surgery (Royer, 1976). More recently, teams have developed whose main task is to provide primary care for patients. For instance, HCTs have developed within neighborhood clinics to provide total health care to neighborhood residents (Wise, 1974), and nursing HCTs are used in hospital environments to enhance patient care (Bloom & Alexander, 1982).

Other HCTs have arisen from health care providers' desire to allow the terminally ill to live out their lives with dignity. These interdisciplinary teams operate within the structure of

hospices, and their goal is to provide support and care for persons in the last phases of disease so patients can live as fully and as comfortably as possible. Such an approach to patient care is viewed by administrators as central to hospices' mission to minister to these very special patients and their families.

Recently the authors and others (Seibold et al, 1986) conducted an evaluation of a midwestern hospital-based hospice and focused on the volunteer and professional components of the hospice team. Among other methods employed, questionnaires were used to assess the volunteers' and professionals' perceptions and attitudes concerning the hospice program and their work within it. While a primary purpose of the evaluation was to provide hospice administrators with feedback concerning volunteer involvement in hospice activities (cf. Seibold, Rossi, Berteotti, Soprych & McQuillan, 1987), further analysis of evaluation results provided us with insights into the character, organization, and quality of staffing in the hospice organization as a whole. In particular, even though a goal of hospice administrators was to assure that program staff and volunteers possessed the abilities to work effectively as <u>team members</u>, it was apparent that these abilities were not being utilized at the time the evaluation was conducted.

This paper analyzes problematic issues surrounding that hospice HCT in light of findings revealed in the literature

concerning HCT structures and processes. Specifically, we discuss the factors of coordination and role definition in HCTs, their manifestations in the hospice evaluated--in terms of both interpersonal dynamics and structural constraints, and we conclude with a review of external and internal efforts that were undertaken to improve the hospice's HCT.

Review of Relevant Issues in HCT Literature

Coordination

Two of the most important factors purported to contribute to an HCT's effectiveness are coordination and role expectations. In the first area, "teamwork implies cooperation rather than conflict and involves social relationships" (Hanney, 1980, p. 71). Members of an HCT must learn how to combine the different skills they bring to the team and to utilize them in a collaborative manner for the good of the patient. While high coordination is a goal of an HCT, it often is difficult to achieve in practice due, at least in part, to an apparent belief among those with formal authority over such groups that medical professionals should not be externally controlled and regulated (Hydebrand, 1973). Stated differently, administrators feel constrained from imposing coordinating structures on the professional health care providers they supervise despite some evidence that suggests that higher quality coordination of nurses, for example, gives rise to higher quality patient care (Bloom, 1979). If high quality patient care is the goal of an

HCT, its members must transcend their individual biases towards group work and utilize mechanisms through which they can coordinate their efforts.

Each HCT must develop its own coordinating mechanisms to suit individual members as well as the larger organizational environment in which the team functions. Typically, there are three kinds of coordinating mechanisms, which Bloom (1979) calls impersonal, feedback, and group methods. The impersonal method is communicated through writing and establishes the structural requirements and boundaries of the team and its functions; such documents as policy handbooks, procedure manuals, and statements of purpose are examples. The feedback method of coordination may be either a written or oral exchange of information. This method is interpersonal in nature and relatively unstructured. Comments on patients' charts or patient care instructions given in the hall are feedback methods of coordination. The third mechanism of coordination is the group method, which is more structured than the feedback method. The group method is in evidence at regularly scheduled, formal group meetings where the HCT members discuss patient care and interact with each other (Ducanis & Golin, 1979).

Role Definitions

Dynamics associated with members' roles in the HCT is the second potentially problematic issue affecting HCT performance and morale, according to researchers in the area (Hanney, 1980;

Fry, Lech, & Rubin, 1974; Beckard, 1974). For example, a very real problem within an interdisciplinary team such as an HCT is the presence of multiple role expectations and role sets. To whom does a team member owe allegiance--the team or perhaps the formal authority of his or her own discipline? Members of the team must work to modify their roles and adapt their skills so that the team can benefit from all members' contributions (Hanney, 1980). The team should provide an "integrated role set"--that is, one in which behavior will match expectations. Hanney suggests that "people who find themselves in an unintegrated role set might get social support from others with similar statuses and difficulties" (Hanney, 1980, p. 5). Instead of looking to the team for support, members look to other members of their own profession for support. This action does not strengthen the team and is symptomatic of a diffuse team (Thornton, 1977).

In intervention work with a health center, Fry et al (1974) found that not only did team members have to cope with multiple role expectations for themselves, but they also had to deal with the multiple expectations of the other team members. Even if a role is clearly defined, expectations clash and members express disgruntlement. Stated generally, the anxiety resulting from the team's inability to clarify roles will interfere with the provisions of effective health care (Fry et al, 1974). In light of the theoretical and empirical importance of coordination and

role expectations to the effective performance of HCTs, we found it instructive to use these constructs to attempt to explain some problematic dynamics within the hospice HCT evaluated.

Hospice Study

The hospice studied has provided terminal health care for the past seven years to over 400 patients and families in a three county area of a large midwestern state. The four major services it offers are home care, palliative in-hospital care, volunteer support, and bereavement follow-up. These services are coordinated by what the organization calls an Interdisciplinary Team. In principle, the group is composed of all hospice workers; in actuality, it is a smaller and more centralized HCT of representatives of the various health care provider groups involved in the hospice program. These people meet once a week to discuss each patient, to plan and to coordinate health care services, and to disseminate information to other providers involved in direct patient care. The center rectangle in Figure 1 shows the members of this group, and the outer rectangle displays the subgroups they represent and/or with which the Interdisciplinary Team interacts.

Insert Figure 1 About Here

Coordination

Coordination and adaptation in health care contexts is achieved primarily through communication "because mutual adjustments must be made as new information is received" (Bloom and Alexander, 1982, p. 85). As discussed earlier, the literature on HCTs points out that it is difficult to integrate and coordinate professional health care providers into a viable work group and even more difficult to coordinate professionals and volunteers in a health care setting. During the evaluation of this hospice HCT, we gathered data concerning two of the methods of coordination discussed earlier, the group and feedback methods. In this section, we will discuss how these methods were operationalized in this HCT and how subsequent coordination problems contributed to (1) the professionals' dissatisfaction with the volunteers' task performance, and (2) feelings of alienation from the team on the part of the volunteers.

Group Method: Interdisciplinary Team Meetings. The interdisciplinary team meeting was the vehicle for the group method of coordination. The weekly meeting was an opportunity for representatives from the various hospice components to exchange information and plan health care and administrative strategies. However, interpersonal conflicts became a barrier to effective communication and, hence, to coordination. For example, data from our evaluation instruments indicate that when members of the Administrative Staff1 were asked how satisfied

they were with the administrative activities of members of their own component (the hospice coordinator, the medical director, and the volunteer coordinator) they indicated a high level of satisfaction with the hospice coordinator, but a relatively low level of satisfaction with the medical director and volunteer coordinator. Although the average levels of satisfaction (see Table 1) with each of these three administrators were within 1 unit of each other, the lower average attitudes toward the volunteer coordinator and medical director ("somewhat unsatisfied" and "very unsatisfied" ratings) reflected different levels of satisfaction from the "somewhat satisfied" and "very satisfied" ratings of the hospice coordinator. Team members' different feelings toward key members of the HCT in turn tended to inhibit the frank and open discussions in HCT meetings so necessary for effective team functioning and coordinated patient care.

Insert Table 1 About Here

More specifically, the professionl staff members most likely to participate in the Interdisciplinary Team meetings seemed to be in conflict with the volunteer coordinator and medical director. Comments made by providers during qualitative portions of the evaluation underscored this conflict.

> "[The Medical Director's] attitude [is] bad! ! esp. bad toward certain staff. . ."

> "[The Medical Director] has a very poor rapport with patients and their families. Staff constantly had to put out fires that he started."
>
> "One can never be sure of his temperament."
>
> "He is an excellent oncologist but lacks in patient and staff P.R. He is at times temperamental, rude, and intimidating to staff, patients, and families."
>
> "The volunteer coordinator had too much influence on program policy."
>
> "[The volunteer coordinator] is in a job for which she is ill suited."
>
> "[The volunteer coordinator] seems to work well with volunteer staff; seldom talks with home health nurses and does not encourage or support communication between [Home Health Nurses] and volunteers."
>
> "[The volunteer coordinator] could listen more to what we tell her instead of doing her own thing."

This polarization between satisfaction with the hospice coordinator on one hand, and the lack of satisfaction with the medical director and volunteer coordinator on the other, served to encourage negative attitudes towards two prominent administrators, which led in turn to inefficient communication and coordination during interdisciplinary group meetings. The medical director was perhaps not bothered by these attitudes as his health care role was not totally linked to his hospice role nor did he often deal directly with other HCT members on a daily basis.2 These attitudes, however, became a severe problem for the volunteer coordinator who, as the lone representative of the volunteers at the meetings, was not accorded the respect and status her position should have given her. As frequently happens

in such situations (Shaw, 1976), this status incongruency subtly structured the coordination mechanisms at the group meetings and subsequent coordination mechanisms used in disseminating information and feedback.

Feedback Method: Information Dissemination. While the interpersonal dynamics of the Interdisciplinary Team meetings led to ineffective use of the group method of coordination, the structure and composition of the group led to ineffective use of the feedback method of coordination. Organizational theory researchers have suggested an interdependent relationship between organizational structure and communication (Conrath, 1977; Guetzkow, 1965; Penley, 1977; Porter & Roberts, 1976; Taylor & Eagle, 1980). Our work with this hospice HCT bears out this relationship.

One structural problem which led to ineffective group practices was the lack of balanced representation of all team members at the Interdisciplinary Team meetings. While the volunteers comprised the largest single group of workers in the hospice program, they were only represented at the weekly meeting by one person--the volunteer coordinator. It fell to this person to disseminate information to over 100 volunteers who donated an average of four hours of their time a week, many of which were not worked at the hospital itself but in the patients' homes. This centralized type of communication may have kept the volunteer coordinator satisfied with her information-giving role

(Schermerhorn, Hunt, & Osborn, 1985; Shaw, 1976), but the volunteers themselves appeared to feel left out of decision-making roles and generally dissatisfied with their limited role in the Interdisciplinary Team. Their requests for more administrative information and more team meetings, (presented later in this paper) bear this out.

The volunteers' feelings of dissatisfaction and alienation may be due in part to their lack of active involvement in the Interdisciplinary Team meetings and also in part to the inability of the volunteer coordinator to adequately disseminate information about the volunteers to other members of the HCT, both during the Interdisciplinary Meetings and during daily work hours. When volunteers were asked to rate the extent to which they felt other team members understood their responsibilities and duties, 97.9% of the volunteers who rated the volunteer coordinator on this question felt that she understood their responsibilities and duties "very much" (Table 2). However, volunteers perceived that other team members understood volunteers' responsibilities and duties substantially less then the volunteer coordinator did. Thus, while the volunteer coordinator kept in touch with the volunteers she was perhaps not providing adequate and/or appropriate information concerning volunteers to other team members. Hence, the volunteers perceived that other team members did not understand their responsibilities and duties.

Insert Table 2 About Here

Turning to the professionals' responses, we found that while 81% of the professionals felt they spent enough time working with the volunteer coordinator, nearly one-third of the professionals felt they had "poor" or "fair" working relationships with her. Additionally, nearly 70% of the professionals felt they received enough information from the volunteer coordinator, but only 28.2% found this information very useful. Tables 3 and 4 contrast the average ratings given by the professionals to the volunteer coordinator and other members of the team. Out of a list of 12 team members, the professionals felt that they spent more time with three people other than the volunteer coordinator, but there were nine people with whom they had better working relationships. The professionals also felt that out of the 12 options, they received more information from two people other than the volunteer coordinator, but they received more useful information from eight people other than from the volunteer coordinator. This pattern of responses suggests that, while the volunteer coordinator may have been trying to disseminate information to HCT members, she was perceived as ineffective in these attempts.

Insert Table 3 About Here

Insert Table 4 About Here

On the other hand, the structure of the Interdisciplinary Team did allow for effective information dissemination for the professionals. Representatives of the professionals at the meetings saw their colleagues more frequently than the volunteer coordinator saw the volunteers, and so could disseminate and coordinate information more easily than the volunteer coordinator could.

In order to assess this notion, the professional staff members were separated into four major groups--Home Health Care Nurses, Administrative Staff, Interdisciplinary Staff, and formally trained hospice nurses.3 Table 5 shows which HCT member each of these "sub-groups" rated highest in terms of the quality of their working relationship and the amount of useful information the member provided. These data demonstrate that the professionals had good working relationships with their professional colleagues and that they looked to these people for useful information.

Insert Table 5 About Here

Feedback Method: Inter-group Communication. What can be further inferred from these data is that the professionals and volunteers were polarized in terms of where useful information and working relationships could be found. Table 2 showed that volunteers felt that the professionals did not understand their duties and responsibilities and Tables 3 and 4 showed that the professionals believed that they and the volunteers spend little time with each other and that their working relationships were relatively poor. Moreover, the professionals felt that they did not receive enough hospice-related information from the volunteers, and that what they did receive was not as useful as it could have been. Thus, the communication among and between these various components of the HCT was poor and contributed to the development of a less efficient team--a common finding (Georgopoulos & Mann, 1962; Zander, 1977).

In general, the inability to coordinate HCT members through the group and feedback mechanisms discussed above inhibited the achievment of quality working relationships among members. Specifically, our evalution results suggest two factors, attributable to inefficient coordination, which hampered the building of quality relationships: (1) the professionals' perceptions of volunteers task performance, and (2) the volunteers' feelings of alienation from the group.

Professionals' Dissatisfaction with Volunteer Performance. Although the volunteers relied heavily on the volunteer coordinator for information, our analysis suggests that she could not disseminate information effectively. Additionally, the volunteers did not seem to be getting the information they wanted from other team members: 60% of the volunteers felt that they received inadequate briefings before seeing palliative care hospital unit (PCU) patients and 42% felt that briefings on home care patients were problematic. Volunteers felt they were receiving inadequate information about hospice activities and patient care.

Research within a variety of organizations suggests a positive relationship between information accessibility and job satisfaction and performance (Allen, Lee & Tushman, 1979; Dewhirst, Arvey, & Brown, 1978; Downs, 1977; Gladstein, 1984). Although the volunteers generally indicated a high level of satisfaction with their tasks, the professionals expressed dissatisfaction with volunteers' performance of these tasks. For instance, the professionals tended to be critical of what they perceived as volunteers' "over-involvement" with patients. They also indicated dissatisfaction with the type of work volunteers attempted to perform. In particular, they felt that the volunteers tried to be professional care givers rather than fill "the appropriate supportive volunteer role . . . of course, their perspective, knowledge, and experiences have not prepared them

for [the professional care giver] role." Other comments made by professionals who responded to this portion of the evaluation underscore this sentiment:

> "Volunteers do not seem to understand the appropriate 'professional' volunteer role which many good and needed 'professional' volunteers understand perfectly."
>
> "It has been my experience working with the volunteers, [that] some appear to play the 'Nurse' role."
>
> "Some volunteers appear to be frustrated nurses and/or mental health workers and are assessing and attempting to correct problems for which they are not qualified to treat."
>
> "There should be limits to what [the volunteers] are allowed to do, so that they have a clear idea of what they are expected to do."

This dissatisfaction may be attributed in part to the lack of information received by the professionals concerning volunteers and their duties, and to the lack of coordination and effective communication between volunteers and professionals. These very same causes were also instrumental in the development of volunteers' feelings of alienation from the team.

Volunteers' feelings of alienation. The evaluation results indicate that 66% of the professionals worked with the volunteers three hours or less per week. This limited amount of contact between volunteers and professionals colored the perspectives of members of both components, making it difficult to discover effective mechanisms for inter-group coordination. Results further suggest that the volunteers felt this lack of coordination more deeply than the professionals. A number of

volunteers commented on the lack of "team spirit" within the hospice HCT and displayed feelings of alienation from the team:

> "[Volunteers need a] feeling of confidence in [their] capabilities by some of the floor nurses and not the feeling that [the volunteers] are there to replace them."
>
> "Oncology nurses were often downright rude to me and doctors dismissed me as unimportant and treated me like an under-worked candy striper . . . it is very frustrating to be dismissed in this manner."
>
> "I preferred the days when we had 'hospice' nurses . . . [then] I felt like part of the team. Now it is hit and miss. Half of the time I don't even know who the nurses handling the hospice [patients] are . . ."
>
> "I feel there is a need for us to know more about the administration of [hospice]. We know there are problems at times but it is all so hush-hush that we feel we are fighting a losing battle and we feel 'left out'."

These feelings of alienation did not seem as widespread among the professionals. Whatever feelings of alienation they might have experienced as members of the HCT could have been offset by a reliance on the high quality intra-group working relationships within the group discussed earlier. Too, the relatively higher status enjoyed by the professionals within the larger hospital organization and health care context could ease feelings of alienation.

The volunteers, however, were not accorded high or professional status within this hospice HCT, as evidenced by the fact that they were not given adequate information about patients and hospice activities. This lack of information left the volunteers less knowledgable about their work and the patients,

and served to demonstrate their low position in the health care provider hierarchy. Both the lack of information and resultant low status of the volunteer component engendered the volunteers' feelings of alienation from the HCT.

Also, the large size of their group and the lack of adequate intra-group cohesion precluded attempts at relying on other volunteers for support even though volunteer-based support systems were available in the organization (Seibold et al, 1987). The fact that their lone representative had low status among the members of the active Interdisciplinary Team further served to keep the volunteers from feeling as though they were an important part of the hospice. Yet, if volunteers are to feel satisfied with their work they need to feel appreciated and worthwhile (Kearney & Carpenter, 1984). As discussed earlier, it was difficult for the volunteer coordinator to disseminate appropriate information to the volunteers. Thus, the volunteers' alienation was exacerbated by lack of information concerning the planning and coordinating activities of the hospice as a whole.

Section Summary. The coordination problems discussed above served to fragment this particular HCT into subgroups, making it difficult to offer optimal patient care. There seemed to be a widening gulf between the volunteers and the professionals, and a subsequent lessening of morale throughout the hospice. While all team members were affected by the lack of effective coordination, it seemed that the volunteers felt the effects most severely.

They received relatively inadequate assurance of status and team membership. What information they did receive tended to be ambiguous and the most ambiguous information concerned their role definitions within the HCT.

Role Definitions, Clarity and Expectations

As we discussed earlier, the presence of multiple role expectations and role sets can lead to problems in HCTs. Members work with a variety of people assuming a variety of roles and should rely on these people for role information. If however, role information is not forthcoming, or if inconsistent role information is received from these multiple sources, members will feel role stress (Quick & Quick, 1984), and thus provide less than optimal patient care (Fry et al, 1974). Additionally, team cohesion will be harmed and members will turn to non-team support systems (Hanney, 1980; Thornton, 1977). Based on these assumptions, in this section we will first look at problems of inadequate role information for the volunteers from the various role senders. Then we will discuss the support systems of the professionals and volunteers and how these systems reinforced the segmentation among the HCT members.

Role Information. Our earlier discussion of coordination in this hospice HCT showed that volunteers looked to the Volunteer Coordinator for hospice-related information. Yet, in terms of specific patient care, they should have relied on the professional health care providers. This did not seem to be the

case. While 90% of the volunteers felt that they received adequate guidance from the volunteer coordinator, nearly one-third of the volunteers who responded to our evalution instruments felt that they did not receive adequate guidance from the nurses with whom they worked. In order for volunteers to feel comfortable in and knowledgeable about their roles within the hospice, they should have received role information from the health care providers with whom they worked.

A common complaint about volunteers made by the professionals was that the volunteers had no well-defined roles within the team. In their words,

> "There are no set duties that the volunteers do. Their role, many times, steps into staff responsibilities."
>
> "The volunteers were not realistic in viewing their role."
>
> "I think volunteers are entrusted with too much information and responsibility . . . they seem to feel they have to have all the answers or obtain the answers instead of simply referring them to the appropriate staff person."
>
> "I feel the volunteers need more guidance and support from the staff nurse[s]."

Yet, it is not clear that the professionals were willing to help clarify the roles of the volunteers. They suggested that the role definition problem was due to the inability of the volunteer coordinator to coordinate/direct effectively, inadequate volunteer training, heavy patient loads, the nature of voluntarism, or overall changes in the hospice program itself. Despite the fact that each patient was attended by both

volunteers and professionals, the professionals did not show a strong desire to increase their own contact with volunteers. Without this increased communication from the very HCT members who were most aggravated with the volunteers (i.e., the professionals), it is not surprising that basic problems with the volunteers role definition occured.

When volunteers wanted to find out what was expected of them during their initial weeks of work after training, 80% indicated that they asked the nurses for role-relevant information, while only 48% received information from the nurses without asking. Interviews with focus groups within the volunteer component suggested that the longer a volunteer had worked at the hospice, the more reluctant they were to ask the nurses or other professionals for role information. Similarly, the longer a volunteer had worked in the hospice, the less likely it was for a nurse or other professional to offer role information without being asked. Thus, volunteers' expectations of their roles might have been unrealistic, resulting in a general perception by the volunteers that their talents and strengths were underutilized by the HCT. Slightly over one-half of the volunteers indicated dissatisfaction with their duties, and underutilization of their talents was seen as the most serious problem with the program by the volunteers. In particular, the volunteers were dissatisfied with what they perceived as the overabundance of menial tasks they were asked to perform:

> "I feel, especially on the weekend, that I could be doing a lot more than I do. I spend a lot of time looking for things to do on the [PCU] unit. That could be because the unit is so quiet lately, but I wish I had more to do."
>
> "I guess my biggest frustration on PCU was that I was more or less only a 'go-for' person. I had so little contact with patients and family but was off Xeroxing on some petty job. I felt my time somewhat wasted when I was only used for errands, etc. A lot of times I felt I was doing the RN's job when she often had only one patient herself."
>
> "I felt the tasks I did while on PCU were neither beneficial to patients or myself."

It appeared that the communication between staff professionals and volunteers on the job was inadequate and led to problems of role definitions for the volunteers.

Support Systems. Underscoring this point was the fact that volunteers and professionals relied on different sources of support, a reliance which further segmented the components and raised problems concerning roles within the team. As Tables 6 and 7 show, both volunteers and professionals turned to administrators for support. Notice, though, that the volunteers relied quite heavily on the volunteer coordinator (61.8% frequently sought her out) while only 39% of the professionals frequently sought out the hospice coordinator, their preferred source of support. Notice, too, that family and friends were sought out more frequently than either peers or other hospice team members.

Insert Table 6 about Here

Insert Table 7 About Here

In terms of role definitions for volunteers, these data point to causes of role conflict for the volunteers. While 62% of the volunteers sought out the volunteer coordinator, only 16% sought out nurses when they needed support. This difference in amount of support, taken together with the difference in amount of guidance received from the volunteer coordinator versus the hospice professionals discussed earlier, certainly was a factor in the development of role conflict for the volunteers: to whom is the volunteer's allegiance owed? An administrator they see infrequently or the health care providers with whom they work?

Theoretically, if a strong team spirit is to be fostered, the volunteers and the professionals should guide and support <u>each other</u> (Hanney, 1980). While both groups felt this kind of contact should be increased, there was no indication that it existed. Thus, the volunteers turned to an administrator for role clarification, guidance and support. Their expectations of what a hospice volunteer is and his/her role in hospice work came from the volunteer coordinator, a person who had limited contact with hospice patients and who, in the hospice studied, was in conflict with other administrators and health care professionals.

<u>Section Summary</u>. What seemed to be occurring in this particular hospice was typical of the traditional approach to

health care rather than a health care team approach, which is its goal. Although the hospice was defined and structured as a team, in effect there was a supervisory board which directed the hospice that met on a weekly basis. As discussed earlier, this group was not composed of a balanced representation of all hospice personnel, making it difficult to fully coordinate and subsequently disseminate information concerning the hospice and patient care. Furthermore, results from our evaluation indicated that the volunteers perceived themselves as "go fers" and felt that they were otherwise underutilized by the hospice. The professionals felt they did not spend enough time working with the volunteers, yet also indicated a limited interest in increasing this shared time.

Lack of role clarification for volunteers kept them in a "fuzzy" relationship with their co-workers specifically and the hospice in general, and thus effective team work could not be achieved. A volunteer might be assigned to a home health care role but had little contact with the home health care nurse or other volunteers assigned to that patient. It was up to the volunteer to seek information about the patient, which meant talking to a nurse or other health care professional. Given the structure of the hospice, this was not an easy task to perform: volunteers were cut off from the main problem-solving group--the Interdisciplinary Team which met weekly--and were reluctant in many cases to cross the invisible barrier between them and the

professionals. While seeking out the volunteer cordinator might have been helpful in some ways, it was not ordinarily a direct link to the volunteer's role as care provider.

Impact of Structure on Coordination and Role Definitions

Thus far, we have emphasized the interpersonal activities of the HCT members in our discussion of coordination and role definiton problems. To gain futher insight into these problems, we found it informative to step back and look at larger organizational issues which were affecting the interpersonal dynamics. In particular, there were identifiable organizational pressures which militated against the decentralized structure endemic to HCTs and which undermined the interdependence and continuity necessary to effective HCT funtioning. In this section, then, we will sketch out the organizational structure of the hospice vis a vis its position within a specific environment. Then we will discuss changes at both the staff and organizational levels, along with the ramifications of these changes on the organizational structure and interpersonal dynamics of this HCT and its members.

According to the National Hospice Organization's (NHO) mandate, all hospices are to use an interdisciplinary team approach to health care. This team approach may be framed by a variety of organizational structures, although there are three general organizational models (Paradis & Cummings, 1986). A free standing hospice is a self-contained hospice facility, separate

from hospitals or other health care agencies. A home health agency-based hospice is a unit of a home health agency, which usually has home health certification. A hospital-based hospice is a unit of a hospital and is viewed as "a way to augment [the hospital's] services to patients and families" (Paradis & Cummings, 1986, p. 374). The hospice we studied was a hospital-based program, but also utilized and depended on the expertise, personnel, and facilities of an independent home health care organization. As a non-revenue producer of the hospital, the hospice was constantly being asked to prove its worth to hospital administrators. Additionally, it was faced with maintaining health care standards and meeting federal, state, and hospital regulations. A small number of both professional and volunteer staff members resented the fact that the hospice was hospital-based and felt that this restricted their practice of the type of health care they wanted to provide. Nonetheless, the hospice, or more precisely, its administrators, reported to hospital administrators and hospital administrators appointed hospice administrators.

This structure was set in place a little over seven years ago, when the hospice began operating. Since that time, the hospice organization has been in a more or less constant state of change. It needed to work out a number of problems resulting from organizational growing pains, problems typical of relatively new organizations (Kimberly & Miles, 1980). First, it faced a

number of turnover problems among its coordinators and directors. The initial hospice coordinator left her position after two years to work in another part of the parent hospital and was asked back by hospital administrators two years later to replace her replacement. She returned, but the length of her tenure remains uncertain.4 There have been two medical directors since the hospice's inception, both of whom were appointed by the hospital administration, rather than requesting the assignment themselves. The woman who filled the volunteer coordinator position when we evaluated the hospice left the organization before the evaluation was completed and was replaced by a registered nurse, who performs the duties on a part-time basis. Furthermore, cutbacks in funding for the hospice unit prompted a reduction in hospice nurses and the need to share a hospital floor with non-hospice affiliated nurses and non-hospice patients.

This relatively unstable state of affairs made the already inherently difficult tasks of coordination and role definition within the HCT all the more difficult. Hospice administrators not only had to oversee the coordination mechanisms within the hospice program itself, but had also to create effective coordination methods to link the hospice with both the hospital and the independent home health agency. In doing so, their own roles had to be negotiated on at least two levels: hospice HCT member and hospital employee. The nurses who spent relatively little time with hospice due to their general hospital

responsibilities also faced more or less daily role changes. Given a choice, it seemed that the staff nurses allied themselvese to the hospital, rather than the hospice. In fact, when we evaluated the hospital-affiliated nursing component of the hospice, we could not go directly to the nurses, but had to work through their supervisor. This access restriction suggests, in part, that the nurses, or at least their supervisor, wanted to maintain a distance from the hospice HCT and build identification with the hospital. In this way, the positioning of the hospice HCT within larger organizational constraints prohibited effective coordination and team building among the HCT components.

Yet more damaging to team-building were the effects of administrative personnel changes on coordination and role definitions. The turnover frequency of the hospice administrators did not help to stabilize coordination mechanisms. Different people will emphasize different forms of coordination, and changes in coordination methods require time to implement. It may be the case that administator turnover and concommitant changes in administrator style happened too frequently for any coordination mechanism to become a stable and integral part of the HCT. Additionlly, such high turnover rates may result in a loss of confidence in adminstration by the members of the team, causing members to (1) turn to groups outside the team for reassurance and support, (2) form component-specific communication networks through which the component's members

coordinate their own activities, and (3) seek role information from whatever stable source they can find. Our earlier discussion details the extent of these problems in the hospice HCT we studied.

From a different perspective, the changes in personnel due to funding cutbacks can also be seen as contributors to coordination and role definition problems. As hospice HCT members had to work more closely with hospital employees because of decreases in funding, new coordination mechanisms had to be incorporated into an already problematic coordination situation. Information would have to go farther out of the hospice in order to include people who did not necessarily want to be part of the team, but who, perforce, became members. Too, this situation led to new problems of role expectations and negotiations, which added stress to an already stressed system. If the volunteers could not get adequate role information from nurses who wanted to be members of the team, how could they negotiate roles with nurses who did not want to be members? This stress on an already stressed system is still being felt and more stress of a similar nature can be expected as funding continues to be difficult to obtain.

A second growing pain problem is tied to the inevitable changes faced by the hospice HCT as a structural entity. Some researchers have argued that as organizations face uncertainty and change, they tend to become similar to other organizations in

their field or to organizations on which they depend for supplies, access to markets, personnel, etc. This process of isomorphism has been discussed by DiMaggio & Powell (1983) in general and by Paradis & Cummings (1986) within the specific context of hospice organizations.

Briefly, these researchers posit that organizations become similar to those organizations with which they work or organizations which are in the same field. These similarities emerge through three mechanisms of change which lead organizations to become isomorphic with other, specific organizations. Coercive isomorphism occurs when organizations on which an organization is dependent place both formal and informal pressures on it. Thus, the pressure is a political force and deals with the problem of legitimacy for the organization in question. Mimetic isomorphism results directly from organizational uncertainty and the resultant need to find other organizations on which to model. Normative isomorphism stems from professionalization, the "collective struggle of members of an occupation to define the conditions and methods of their work" (DiMaggio and Powell, 1988, p. 152).

These three isomorphic processes were at work in the hospice studied. Yet, due to its peculiar structural positioning, it was not clear on which organization or organizational field it should have modelled itself. Clearly, its initial structuring as a hospice was based on other hospice organizations. Yet, its close

ties to both a hospital and an independent health care agency influenced the isomorphic processes affecting its structure and, subsequently, the coordination and role definition processes within the HCT.

This hospice HCT experienced coercive isomorphic processes as it tried to implement a team approach to health care within the context and contraints of hierarchically structured organizations. DiMaggio and Powell (1983) point out that "the need to lodge responsibility and managerial authority at least ceremonially in a formally defined role in order to interact with hierarchical organizations is a constant obstacle to the maintenance of egalitarian or collectivist organizational forms" (p. 151). Both the hospital and the health care agency exerted pressure, however subtle, on the hospice HCT to conform to their structural models and utilize their coordination mechanisms and role definition processes rather than the prototypical hospice models. At the same time, the hospice organizational field exerted pressure in the form of imposed regulations and standards. Concurrent with our evaluation, the hospice was seeking NHO accreditation and state licensing and thus felt the pressures to conform to hospice organizational standards, including the team approach to health care, more strongly than ever before.

These various pressures to become substantially two different organizations in terms of the team approach left the

hospice in a state of uncertainty. Generally, mimetic isomorphic processes arise out of uncertainty; for instance, when an organization tries to develop its own agenda in response to environmental ambiguity. Accordingly, organizations tend to model themselves on other organizations in their fields that they see as more "legitimate." In trying to establish its own identity through mimetic processes, this hospice had to struggle to avoid modelling itself on non-hospice organizations.

This struggle to achieve its own place as a hospice and as part of the larger health care organizations caused structural confusion. Developing a hospice structure would involve rejecting the traditional structures imposed on it, as well as the funding and assistance coming from the traditional organizations. Much like the inconsistent role definitions its volunteers received, the hospice organization was receiving inconsistent organizational role definitions. This structural confusion may have been filtering down to the operational levels of this hospice HCT, thus adding more confusions and ambiguity to the already strained interpersonal relationships.

It may be the case, though, that normative isomorphic pressures will become more relevant than other pressures on both the structure and the daily work of this hospice HCT. Normative pressures in this HCT would stem from the members themselves, as they try to create organizational norms to define the conditions of what it is to work as a member of the HCT (DiMaggio & Powell,

1983). These pressures may have already begun. Since the evaluation was completed, the hospice was granted state licensing and NHO accreditation. Thus, the need to ba a "good hospice" may take on added importance for the members and increase the sense of "professionalism" for both paid staff and volunteers alike. In fact, as our later discussion on implementation of intervention suggests, members of this HCT have begun to actively pursue means to improve coordination and increase their input in defining their roles within the team.5

Summary

Working in a hospice places unique demands on both the professional and volunteer health care providers. Cooperation and teamwork can serve to ease some of the stress these individuals feel and can contribute to sound patient care. However, the organization's goal of effective teamwork, as stated in its formal documents, does not seem to have been maximally achieved in the hospice studied. In part, this failure appeared to be due to ineffective use of coordinating mechanisms, particularly the feedback mechanism (Bloom, 1979). Another factor contributing to this failure was the ambiguous role of the volunteer and consequent internal separation of the volunteer and professional components of the hospice. Furthermore, subtle organizational pressures were at work persuading the organization to conform to certain models of organizationas structure. In particular, these factors needed to be addressed in order to

offer the hospice administration strategies for improving what had become a weak team approach to patient care. Therefore, we suggested intervention strategies which we felt would best assist this hospice HCT in developing their team strategies.

Intervention

The intervention took the shape of a three-stage program, including implementation of the recommendations. The first stage consisted of the submission of a formal report which presented the results of our evaluation instruments and initial recommendations for improving coordination and role definitions. The second stage involved debriefing sessions with the two major components of the HCT, the professionals and the volunteers. At these meetings, we solicited suggestions from the HCT members on ways to improve team interaction. Stage three, the implementation stage, was just beginning at the time this paper was written. This section presents detailed descriptions of each of these intervention stages.

Stage One

As the initial stage of the intervention process, recommendations were presented to the hospice administration in report form. Specifically, we suggested that in order to strengthen the coordinating mechanisms already in use

(1) A more effective and efficient system of communication about individual patient care should be developed, and each member of the health care team should be involved in the communication process.

(2) The volunteer coordinator should better inform appropriate professional staff of the duties and responsibilities of the volunteers.

(3) More frequent and effective interaction between the professional and non-professional staff should be systematically encouraged.

A fourth recommendation concerning roles stated that

(4) The roles of the volunteers should be clearly defined at the selection stage and periodically redefined throughout their involvement in the hospice.

Additionally, as an aid in promoting "team spirit" and cooperation between the volunteers and professionals, we recommended that

(5) A ceremony be held to mark the end of each training session, open to all volunteers and members of the professional staff.

Stage Two

Roughly two months after these recommendations were submitted, members of the evaluation team conducted debriefing sessions with the professionals and volunteers respectively. At both sessions the results of the evaluation were presented and questions from the hospice staff were answered. The first session was conducted at a regularly scheduled Interdisciplinary Team meeting. After the presentation of results and recommendations, team members discussed various means for improving interactions with volunteers. A number of mechanisms had been articulated by the end of the meeting, including suggestions to

- Hold informal meetings between subgroups of volunteer and professionals to encourage communication on both formal and informal levels.
- Provide a means for formal feedback concerning the Interdisciplinary Team meetings to the volunteers, potentially in the form of short reports or minutes.
- Provide means for professionals to more easily communicate with volunteers about patients during the care giving process.
- Increase efforts by professional staff members to praise volunteers for their work.
- Institute a performance appraisal process for the volunteers which would apprise them of any problems with their performance and reinforce well-performed tasks.
- Invite to the Interdisciplinary Team meeting those volunteers working with the particular patient being discussed.

The second debriefing session was conducted during a volunteer meeting. After hearing our evaluation results and recommendations, the volunteers present discussed suggestions similar to those proposed by the professionals and further suggested that

- "Family logs" be kept at the patients' homes and made available to hospice workers so that all workers assigned to that patient would know what kinds of treatment the patient had undergone.
- Patient updates be kept at the hospital and made available to those volunteers who wanted the information.
- Professional staff members initiate contact with volunteers to communicate information about patients.

The last suggestion reflected volunteers' apprehensions about contacting the professionals first and thereby crossing what they perceived as the bounds of their role within the hospice program.

Stage Three

While our more formal recommendations and the organization members' own suggestions will take time to implement (e.g., performance appraisal process, structured feedback reports), some of the less formal proposals already have been implemented. During the month between our debriefing sessions with the professionals and volunteers, an informal meeting of selected volunteers and professionals was held at the Medical Director's home. The effort and gesture of appreciation by the Medical Director was especially significant in the eyes of volunteers. Earlier evaluation results revealed that he was widely resented by volunteers for the professional "distance" he maintained with them and for his antagonistic relationship with the volunteer coordinator. The team members present at this meeting indicated that the meeting was beneficial to them because they had the opportunity to interact face-to-face with team members whom they rarely saw but with whom they often indirectly communicated. The volunteers and professionals felt that this meeting served as a kind of "ice breaker" and that they would be more willing to talk with each other during the course of daily patient care. This meeting therefore began to break down the imaginary lines between professionals and volunteers, and to reduce the apprehension

about who should speak to whom first about patient care. The meeting also allowed team members to begin to appreciate the hospice program as an integrated whole by encouraging members to find out first hand the kind of general patient care and services other members provided.

A second recommendation which has been accepted is holding a recognition ceremony at the end of volunteers' training. Because the Spring training session is only just beginning, the results of such a ceremony cannot be assessed. However, the hospice personnel believe that this kind of ceremony should contribute to the development of a cohesive team.

These initial steps indicate a willingness on the part of the hospice staff members to develop a cohesive HCT. Of course, it will be important to the team's development that this willingness continue and that further steps be taken. As our analysis of the HCT's problems underscores, the hospice administration still must deal with improving coordinating mechanisms and clarifying volunteers' roles in the hospice program. The proposed recommendations and the members' own proposals concerning these issues should be implemented so that a unified health care team can practice effective and quality patient care.

Conclusions

In this paper, we have attempted to incorporate findings from the literature on HCTs concerning coordination and role

definition with findings from an evaluation of a hospice HCT to gain further insight into these factors of the team approach to health care. In so doing, we found a number of interpersonal and structural factors which mediated the use of coordination mechanisms and affected the role defining processes in this HCT.

First, we noted that the group coordination mechanism, the weekly Interdisciplinary Team Meeting, was ineffective on two grounds: (1) the interpersonal dynamics of the members led to strained and ineffective communication among the members, and (2) the structure of the team denied information access to the volunteers, a substantially large component of the hospice HCT staff. Second, we discussed the ineffectiveness of two types of feedback coordination mechanisms, information dissemination and intergroup communication and how these led to the professionals' perception of poor performance by the volunteers and volunteers' feelings of alienation from the team. Third, we turned to problems of role definitions in this HCT and subsequent use of inappropriate support systems and the subsequent detrimental affects on team cohesion and development. Fourth, we suggested that the changes in both personnel and organizational structure directly impinged on the ability to build an effective team through coordination mechanisms and role definition processes. Finally, we presented intervention strategies which we offered to the hospice HCT members in three related stages.

While we have presented a number of findings concerning coordination and role definitions in a hospice HCT, it should be noted that our findings are based on an evaluation originally conceived to assess volunteer involvement in this hospice. Thus, we were limited by the original goals of the evaluation and their impact on the structure of our evaluation instruments. For instance, the evaluation did not include gathering data from patients or their families concerning hospice practices and health care delivery. Therefore, we cannot report any direct information regarding patient care or perceptions of the HCT members from this important source. Additionally, the generalizability of our findings is limited, of course, due to our method. In particular, our analyses of interpersonal dynamics is specific to this one HCT, although similar problems might be expected to appear in other hospital-based hospice HCTs. Too, our instruments revealed attitudes and information present at one point of this HCTs evolution. No follow up data collection was performed to assess this HCT other than the intervention work discussed earlier in this paper. Thus, the validity of our findings is constrained by this one-time assessment of attitudes and information.

Nonetheless, through this case study of a hospice HCT may contribute to the general knowledge of both HCTs in general and hospice HCTs in particular. We have added support to the general belief that ineffective coordination and ambiguous role

definitions will hamper effective team development. More work is needed that goes beyond case studies and intervention work to understand general patterns of team development in HCTs. Questions such as the following need to be addressed: What is the effect of size of the team on team development, coordination mechanisms, and role definitions? Bloom and Alexander (1982) address this issue in terms of team nursing, with results that suggest there is a link between team size and coordination mechanisms, but continued research on HCTs in general may prove enlightening. Too, our analysis suggests very real problems between volunteers and professionals within an HCT. This problem has been noted in the literature, yet there seems to be little work done on the specific perceptual difficulties these groups face when dealing with each other. Studies concentrating on perceptions of working relationships between volunteers and professional health care providers within HCTs could shed light on more effective means of coordinating these two groups in order to build "team spirit" and provide more effective health care.

Our analysis also provides some information concerning the connection between team cohesiveness and the structure of support systems. More careful attention should be paid to this relationship in order to ascertain the magnitude of its impact on both team morale and health care delivery. It may be the case that in an HCT such as a hospice, seeking support from people outside the team may be more beneficial to both team morale and

health care delivery, given the immense emotional strain attached to caring for the terminally ill and their families.

While we have briefly noted the relationship between organizational structure and its effects on this HCT, further research could better assess this relationship. For instance, subsequent research might compare the three general types of hospice HCTs--free standing, home health care affilated and hospital-based hospices--to see if the organizational structures play a significant role in the development of the team.

Due to our lack of data concerning actual patient care, we could not make any claims concerning the impact that coordination and role definition problems have on actual patient care. Nonetheless, this area deserves further research consideration. While Bloom (1979) points out evidence suggesting that higher quality coordination among nurses leads to higher quality patient care, further work may provide us with more precise descriptions of the types of coordination which are best suited for the different types of HCTs. Additionally, different types of teams may require relatively ambiguous role definitions in order to carry out quality patient care. Studies specifically directed at these issues may provide us with valuable insight into the connections between patient care and team attributes.

Future research might also provide us with clearer definitions of the different types of HCTs presently used in health care. "Health Care Team" has come to mean many different

things. Bloom & Alexander (1982) have pointed out that "team nursing rarely has been conceptualized in theoretical terms" (p. 84). The same can be said for other types of HCTs. Efforts in this direction are needed to provide a better framework from which to study HCTs and their use of coordination mechanisms and role definition processes.

Notes

1. The Administrative Staff consisted of the medical director, volunteer coordinator, hospice coordinator, home health care nursing supervisor, oncology nursing supervisor, consulting psychologist, pastoral care director, bereavement coordinator, hospice secretary, and dietician.

2. In fact, the Medical Director was not only affiliated with the parent hospital of this hospice, but also another local hospital. Thus, he could rely on a variety of support sources for affirming his health care role as a physician.

3. The composition of the Administrative Staff is presented in an earlier note. The Home Health Care Nurses were those professionals who were affiliated with the independent home health care agency which worked with hospice. The Interdisicplinary Staff consisted of social workers, dieticians,

and regular hospital nurses. Formally trained hospice nurses were those nurses who had received training in this special area of health care.

4. A recent article in the local newspaper indicated that a new hospice coordinator has been hired, although we are not sure when she took over this position.

5. Recently, a group of six volunteers asked community hospitals "to create a community-wide hsopice program (Dodson, 1987, p. A-3). This request, occuring about one year after the hospice received accreditation, may point to the increase of mimetic isomorphic processes vis a vis other hospice organizations. In fact, volunteer spokesperson indicated that this "community" hospice would be modelled on a program in a nearby community. Additionally, the fact that volunteers are requesting this program may point to increased normative isomorphic pressures.

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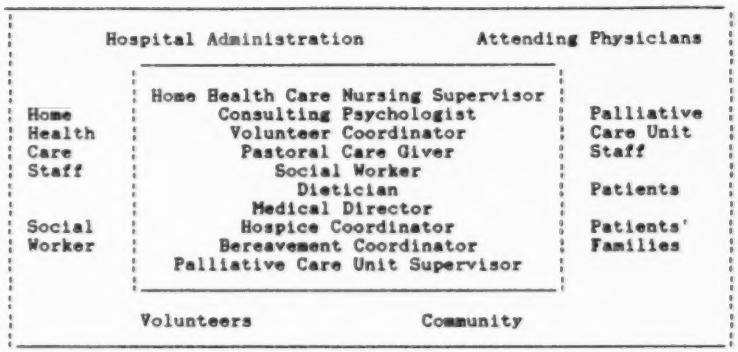

Figure 1. Members of the Interdisciplinary Team

Table 1

Administrative Staff's Satisfaction with Administrative Activities of Key Personnel

HCT Member	Very Unsatisfied 1	Somewhat Unsatisfied 2	Somewhat Satisfied 3	Very Satisfied 4	Average Response (1-4)	Number of Respondents
Hospice Coordinator	50.0%	50.0%	-	-	3.5	8
Volunteer Coordinator	38.0%	25.0%	12.0%	25.0%	2.75	8
Medical Director	43.0%	14.0%	29.0%	14.0%	2.78	7

Table 2

Volunteers' Perceptions of Professionals' Understanding of Volunteers' Duties

HCT Member	Not at All 1	Not Much 2	Somewhat 3	Very Much 4	Average Response (1-4)	Number of Respondents
Volunteer Coordinator	-	-	2.1%	97.9%	3.96	145
Floor Nursing Staff	1.6%	6.6%	21.3%	70.5%	3.61	122
Pastoral Care Staff	2.4%	6.1%	28.0%	63.4%	3.52	82
Bereavement Coordinator	0.9%	8.6%	37.1%	53.4%	3.43	116
Medical Director	-	1.3%	55.0%	43.7%	3.42	151
Home Health Nursing Staff	2.2%	11.6%	31.9%	54.3%	3.38	138
Hospice Coordinator	5.4%	11.7%	32.4%	50.5%	3.28	111

Table 3

Professionals' Rating of Working Relationships with Other HCT Members

Average Ratings of Amount of Time Worked with Other HCT Members		Average Ratings of Quality of Working Relationships with Other HCT Members	
HCT Member	Average Response (1-3)*	HCT Member	Average Response (1-4)**
Home Health Care Nursing Supervisor	2.0	Hospice Coordinator	3.4
Medical Director	1.9	Consulting Psychologist	3.2
Oncology Nursing Supervisor	1.9	Social Worker	3.1
Volunteer Coordinator	1.9	Oncology Nurses	3.1
Oncology Nurses	1.9	Home Health Care Nurses	3.1
Pastoral Care Staff	1.9	Oncology Nursing Supervisor	3.0
Dietician	1.9	Home Health Care Nursing Supervisor	3.0
Hospice Coordinator	1.8	Pastoral Care Staff	3.0
Social Worker	1.8	Dietician	2.9
Home Health Care Nurses	1.8	Volunteer Coordinator	2.9
Consulting Psychologist	1.7	Volunteers	2.8
Volunteers	1.6	Medical Director	2.5

*Average response based on the following scale: Not Enough Information = 1; Enough Information = 2; More Than Enough Information = 3.

**Average response based on the following scale: Poor Relationship = 1; Fair Relationship = 2; Good Relationship = 3; Excellent Relationship = 4.

Table 4

Professionals' Rating of Information Received from other HCT Members

Average Ratings of Amount of Information Received		Average Ratings of Usefulness of Information Received	
HCT Member	Average Response (1-4)*	HCT Member	Average Response (1-4)**
Hospice Coordinator	3.0	Hospice Coordinator	3.6
Social Worker	2.9	Home Health Care Nurses	3.5
Volunteer Coordinator	2.9	Consulting Psychologist	3.4
Pastoral Care Staff	2.8	Oncology Nurses	3.3
Home Health Care Nursing Supervisor	2.8	Medical Director	3.2
Home Health Care Nurses	2.8	Social Worker	3.2
Oncology Nurses	2.7	Oncology Nursing Supervisor	3.1
Volunteers	2.7	Home Health Care Nursing Supervisor	3.1
Dietician	2.7	Volunteer Coordinator	3.1
Oncology Nursing Supervisor	2.6	Dietician	3.0
Consulting Psychologist	2.6	Volunteers	2.8
Medical Director	2.6	Pastoral Care Staff	2.8

*Average response based on the following scale: No Time = 1; Not Enough Time = 2; Enough Time = 3; More than Enough Time = 4.

**Average response based on the following scale: Not Useful = 1; Somewhat Useful =2; Useful = 3; Very Useful = 4.

Table 5

Professional Sub-groups Ratings of (1) Best Working Relationship and (2) Provider of Most Useful Hospice-related Information

	Highest Rated Working Relationship		Provider of Most Useful Information	
Sub-group	HCT Member	Average Response (1-4)*	HCT Member	Average Response (1-4)**
Home Health Care Nurses	Home Health Care Nurses	3.45	Home Health Care Nurses	3.6
Administrative Staff	Medical Director	3.27	Hospice Coordinator	3.58
Inter-disciplinary Staff	Hospice Coordinator	3.3	Medical Director	3.58
Formally Trained Hospice Nurse	Hospice Coordinator	3.47	Hospice Coordinator	3.6

*Average response based on the following scale: Poor Relationship = 1; Fair Relationship = 2; Good Relationship = 3; Excellent Relationship = 4.

**Average response based on the following scale: Not Useful = 1; Somewhat Useful =2; Useful = 3; Very Useful = 4.

Table 6

Volunteers' Sources of Support

HCT Member	Never 1	Rarely 2	Sometimes 3	Frequently 4	Average Response (1-4)	Number of Respondents
Volunteer Coordinator	3.9%	8.1%	24.3%	61.8%	3.42	136
Hospice Coordinator	14.1%	17.8%	34.1%	34.1%	2.88	135
Family	27.1%	15.0%	31.6%	26.3%	2.57	133
Friends	30.1%	15.8%	31.6%	22.6%	2.47	133
Volunteers Trained With Volunteers In General	28.9%	21.5%	26.7%	23.0%	2.44	135
Oncology Nurses	35.1%	18.3%	33.6%	13.0%	2.24	131
Volunteer Advisory Committee Members	55.0%	21.7%	14.7%	8.5%	1.77	131
Clergy	63.6%	9.8%	16.7%	9.8%	1.73	132
Home Health Care Nurses	61.2%	19.4%	16.3%	3.1%	1.61	129
Consulting Psychologist	74.8%	13.7%	9.9%	1.5%	1.31	131

Table 7

Professionals' Sources of Support

HCT Member	Never 1	Rarely 2	Sometimes 3	Frequently 4	Average Response (1-4)	Number of Respondents
Hospice Coordinator	9.8%	7.3%	43.9%	39.0%	3.1	41
Family	18.6%	14.0%	34.9%	32.5%	2.8	43
Friends	27.3%	11.4%	25.0%	36.3%	2.7	44
Home Health Care Nurses	23.3%	30.2%	11.6%	34.9%	2.6	43
Oncology Nurses	22.7%	36.4%	18.2%	22.7%	2.4	44
Hospice Physicians	27.3%	29.5%	20.5%	22.7%	2.4	44
Volunteer Coordinator	31.8%	13.6%	40.9%	13.7%	2.4	44
Consulting Psychologist	27.9%	27.9%	34.9%	9.3%	2.3	43
Volunteers	36.4%	31.8%	27.3%	4.5%	2.0	43
Clergy	53.7%	26.8%	17.1%	2.4%	1.7	41
Volunteer Advisory Committee Members	78.6%	2.4%	14.3%	4.7%	1.5	42